FIRST STEPS PRIVATE MEDICAL INSURANCE CONSENT

State Form 51308 (R2 / 4-06) / BCD 0085
Division of Disability and Rehabilitative Services

First Steps

Effective May 01, 2006

This form is to be completed by each First Steps family who is allowing First Steps to access private medical insurance benefits. A completed copy of the Private Medical Insurance Supplement form and a copy of the insurance card must be attached.

NOTE: Do not complete this form for Hoosier Healthwise or CSHCS.

Name of child	Date of birth (*month, day, year*)	County

First Steps services in Indiana are covered, in part, by State and Federal funding. For example, child find activities, evaluation and assessment, the development of an Individualized Family Service Plan (IFSP) and service coordination are provided at no cost to families. The law does require eligible families to assist in financially supporting other early intervention services through cost participation. Your intake coordinator or service coordinator should have discussed your level of participation, which allows you to choose to participate through a First Steps co-payment fee through your insurance plan. All families are being asked to provide written consent allowing First Steps to access your private insurance to assist in financially supporting their early intervention services received through the system.

Indiana legislation assures that insurance payments for First Steps early intervention services are not counted toward your child's lifetime benefit cap. The only exception is for self-funded health insurance policies, where your employer pays for your health related costs. Self-funded health insurance plans are not required to follow the specific terms of the insurance legislation. The State of Indiana and Indiana state-funded university health insurance policies are covered under the legislation, although they are self-insured plans. Families with self-insured health insurance policies are encouraged to talk with their employer to better understand their benefit plan and coverage limits.

I _____, hereby authorize the First Steps system to:
(*Parent / legal guardian*)

- Release necessary information to the insurance company(ies) designated below; and
- Request necessary information from the insurance company(ies) designated below.

_____
Name(s) of insurance company(ies)

Necessary information may include my child's diagnosis, service dates, services and other information necessary to process my insurance claims for payment to the First Steps system. I consent to the release of this information and understand that I may cancel my consent, at any given time, by notifying my intake coordinator or service coordinator. The cancellation will be effective upon the date the notice is received.

I further consent to allow the First Steps system to bill the insurance company(ies) listed above for the early intervention services provided to my child and family. By giving consent, I am assigning benefits to the First Steps system. If an insurance payment is made directly to me for First Steps services, I will forward these payments directly to the First Steps Central Reimbursement Office. I will also notify my service coordinator of any changes to my health insurance policy, as well as any denial information.

My rights and responsibilities relating to the First Steps system and payment of services have been explained to me. I thereby agree to the terms of this consent and allow First Steps to bill and accept payment from my child's health insurance plan. I may terminate this consent at any time by providing notification to the intake coordinator or service coordinator. I have been fully informed that failure to allow First Steps to access my private health insurance will result in termination of all First Steps services with the exception of evaluation and assessment activities and service coordination, or I can opt to be billed a maximum of $120 per service, up to $960 monthly, which is the maximum cost share per service and maximum monthly cost share amount per family.

Signature of parent or legal guardian holding the authority to authorize insurance payment	Date (*month, day, year*)
Signature of Service Coordinator	Date (*month, day, year*)

DISTRIBUTION: Original - SPOE; Copy - Service coordinator and family